



Athletic Pre-participation Medical Release Form

Participants Name:		DOB:	Age:	Grade:
Address:		Phone Number:		
Parent/Guardians Name:				
Please Circle Sport Football Cheerleading Soccer				
Please Complete the Questions Below:				
1. Has the participant ever been hospitalized for a serious injury or illness?		Yes or No		
2. Is the Participant currently under the care of a physician or taking any medication?		Yes or No		
Please List _____				
3. Does the Participant have any known Allergies?		Yes or No		
4. Is the Participant Allergic to any Medications or Food?		Yes or No		
Please List _____				
5. Does the Participant wear prescribed glasses?		Yes or No		
6. Has the Participant ever blacked out, been knocked out, lost consciousness or been dizzy during or after physical activity?		Yes or No		
7. Has the Participant ever had a racing heart or heart murmur?		Yes or No		
8. Has the participant ever had a Head Injury?		Yes or No		
9. Has the Participant ever had a seizure?		Yes or No		
10. Is the Participant required to wear special protective/corrective equipment?		Yes or No		
(for example: knee brace, foot orthotics, ankle brace, hearing aid , etc.)				
Official Use for Licensed Physician ONLY *Station Based Exam Only*				
Height:	Weight:	Blood Pressure:		Pulse:
		Normal	Abnormal	Physician Initials
Asthma				
Heart				
Pulse				
Lungs				
Abdomen				
Muscular Skeletal				
Should there be any limitations placed on the participants participation				Yes or No
If No Please Explain:				
I certify that I have on this date examined the participant and that on the basis of the examination requested by North Bronx Youth Sports Association the Participants medical history as furnished by me, I have found no reason which would make it medically inadvisable for this participant to compete in supervised athletic activities.				
Physicians Signature :			Please Stamp Here	
Physicians Telephone No. :				
Date:				